DIRECTOR OF NURSES(DON)/ADMINISTRATOR STATEMENT

The following questions are to be answered and signed by the Director of Nurses or Administrator for all patients in skilled nursing facilities when a hearing aid is considered for purchase through the Medical Assistance Program.

1. Has the patient been wearing a hearing aid?

   Yes_____ No_____ If yes, for how long?_____

2. Do you feel that this patient will utilize a hearing aid if the Rhode Island Medical Assistance Program authorizes the purchase of a hearing aid?

   Yes_____ No_____

3. Are you of the opinion that this patient will derive sufficient social/medical benefits to justify the purchase of a hearing aid?

   Yes_____ No_____

Patient Name:_____

Facility Name:_____

Name of DON/Administrator:_____

Signature of DON/Administrator:_____

Date:_____